

2.1.2 Treatment and Prevention: Performance Indicators

The choice of these indicators was made after considerable deliberation and "trial and error" over the past three years that has resulted in the acceptance of several selection criteria:

- they address major functional areas of our budget structure (i.e., major health programs)
- they represent I/T/U priority areas in terms of addressing health problems
- they are relatively passive to I/T/U providers in that they are extracted from existing data systems and do not add to their workload
- they do not reward under reporting of conditions (i.e., reducing complication of diabetes was dropped for this reason)
- they are evidenced-based and support recognized standards of care

While not all treatment and prevention indicators measure up to all these criteria, most come close. It is important to acknowledge that for many indicators, a measurable change in the ultimate outcome is not likely to be seen in the one-year time span of the performance plan. Similarly, the target levels that can be accomplished for many treatment and prevention indicators may not be related to funding levels in a simple linear relationship in a one-year period. Recruiting additional health care providers coupled with securing the needed clinical space to utilize them efficiently many require several years before significant improvements to access are realized. In some cases, investments in the supportive infrastructure are the highest priority for long-term effectiveness but will do little in the short-run to increase access to services.

The data that support the treatment and prevention indicators comes from several sources but the largest number are extracted from the IHS automated information system which collects data on the services provided by IHS and tribal direct and contract programs. In addition, the diabetes treatment indicators 2-5 are extracted from the IHS Diabetes Audit that is an annual systematic audit of almost 10,000 charts. Beginning in FY 2001, these indicators will be based on three-year running averages from this audit.

The software used by IHS facilities and most tribal facilities is the Resource and Patient Management System (RPMS). Data are collected for each inpatient discharge, ambulatory medical visit, and dental visit (all patient specific) and for community health service programs including health education, community health representatives, environmental health, nutrition, public health nursing, mental health and social services, and substance abuse (all activities

reporting systems). The patient-specific data are collected through the Patient Care Component (PCC) of the RPMS. For a discussion of data validation processes relative to this system and the diabetes audit, see Appendix A.1 on page 124.